This form MUST be submitted for every dependent child between the ages of 19-26

Kentucky Employees' Health Plan
2011 Certification of Dependent Eligibility
Must be submitted for covered dependents ages 19 to 26

Section I: Statement of Dependency

_____ _____
Name of KEHP Member | Member's Social Security Number

_____ _____
Name of Dependent | Dependent's Social Security Number

_____
Dependent's Date of Birth

Section II: Dependent's Status

Does the dependent meet the dependent eligibility criteria for Kentucky Employees' Health Plan? □ Yes □ No

Is this Dependent Employed? □ Yes □ No

Name and Address of Employer: _____

Does this employer offer health insurance for which this dependent is eligible? □ Yes □ No

Section III: Acknowledgement

I, the member, and I, the dependent referenced above, do certify under penalty of law that the information I have provided on this affidavit is correct and complete. I understand that omissions or incorrect statements made by me on this affidavit could lead to (1) retroactive loss of benefits for the dependent named above; (2) disciplinary action, up to and including termination of employment; and (3) civil and/or criminal penalties.

I understand that this form is not an application for insurance coverage and that the purpose of this form is to establish eligibility of dependent persons named herein for the coverage provided under the Kentucky Employees' Health Plan.

I understand that this signed affidavit will be retained in my employee benefits file.

_____ _____
Print Name of Member | **Print Name of Dependent**

_____ _____
Signature of Member | **Signature of Dependent**

_____ _____
Date | **Date**

Mail to KEHP at: 501 High Street, 2nd Floor, Frankfort KY 40601